Minnesota Housing Finance Agency

VERIFICATION
of Serious Mental Illness
for the BRIDGES PROGRAM

Print Applicant Name:	

This form may be verified by attaching a copy of a statement from a doctor or mental health professional.

☐ I hereby verify that the Applicant **meets the Minnesota Comprehensive Mental Health Act definition of having a serious mental illness.**

☐ I hereby verify that the Applicant **does not meet** the Minnesota Comprehensive Mental Health Act definition of having a serious mental illness.

Documents to confirm this determination are contained in a consumer's case file.

Print Name of Mental Health Professional:	
License/Qualification of Mental Health Professional:	
Signature of Mental Health Professional:	
Date of Signature:	
Telephone Number:	
Fax Number:	
Address:	

Return this form to the following address:	Housing Agency:	
	Address:	